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L'altissimo tasso di mortalità nelle case di riposo in tutto il mondo è stato giustificato in questi mesi da una narrazione comune a tutti i paesi colpiti dal "covid": una gestione scellerata avrebbe fatto sì che i malati venissero trasferiti nelle case di riposo scatenando il contagio tra le persone più fragili.

Singoli episodi emersi dalla stampa internazionale sembrano tuttavia evidenziare la presenza di altre problematiche più inquietanti come l'abbandono terapeutico e la somministrazione indiscriminata di cocktail di oppiacei e psicofarmaci, anche in assenza di una valida diagnosi. Varie associazioni e giornalisti indipendenti in diversi paesi hanno denunciato uno sdoganamento di pratiche eutanasiche sulla base dell'età del paziente e sul presupposto che nel caso dei pazienti più anziani non valesse la pena intraprendere la via della ventilazione forzata nè tantomeno un percorso di cura di alcun tipo.

English auto translation:

The very high mortality rate in old people's homes around the world has been justified in recent months by a narrative common to all the countries affected by the covid: a mismanagement would have caused the sick to be transferred to the homes unleashing contagion among the most fragile people.
However, individual episodes that have emerged from the international press seem to highlight the presence of other more disturbing problems such as therapeutic abandonment and the indiscriminate administration of cocktails of opiates and psychotropic drugs, even in the absence of a valid diagnosis. Various associations and independent journalists in various countries have reported that euthanasia practices have been encouraged on the basis of the patient's age and on the assumption that in the case of older patients it was not worth taking the route of forced ventilation or a course of treatment of any kind.

https://www.tpi.it/cronaca/malata-covid-morta-legata-imbottita-di-morfina-storia-wanda-20200514602675/

MILANO – "Mia madre ha subito una tortura vera e propria. Era dolcissima, buona e generosa. Non avrebbe fatto mai male a nessuno. Me l'hanno fatta impazzire in cinque giorni in ospedale. Non dormo più. Piango tutti i giorni. **L'hanno imbottita di morfina, ansiolitici, antipsicotici, antidepressivi, altri oppiacei fino a quando il suo cuore ha ceduto. Tutto questo solo perché non sopportava il casco.** Me l'hanno immobilizzata anche alle braccia e alle gambe, come se fosse una criminale forzuta, invece pesava 58 kg ed era alta 160 cm. Non mi hanno mai detto niente. Niente. E soprattutto mai che stavano praticando l'eutanasia, perché questa è! Poi se vogliamo chiamarla cura palliativa, che accompagna il paziente alla morte, la sostanza non cambia. Capisce?!". Questo è il grido di dolore disperato di **Piero**, 43 anni di Milano, ex consulente finanziario, che non riesce a darsi pace. Sua madre, **Wanda**, di 75 anni, di Ariano Arpino, aveva un leggero diabete che curava solo con la dieta, viveva con un rene solo, asportato per un cancro decenni prima. Conduceva, come racconta Piero, una vita serena e aveva sotto controllo la sua salute in maniera esemplare. Ogni tanto soffriva di attacchi di panico ed era in cura per questo. Era stata contagiata dal Coronavirus, ma la situazione era sotto controllo inizialmente.

https://www.globalresearch.ca/were-conditions-high-death-rates-care-homes-created-purpose/5714251

Therefore the nurse could well have been complying fully with the new rules by diagnosing Plaxton's mother with a novel-coronavirus infection based on her having diarrhea alone (and without telling Plaxton any of this).

Furthermore, since transfer to a hospital was not an option (as per 'Condition Set Two') and since COVID-19 is deemed to be very frequently fatal in the elderly, this may be why the head nurse pushed Plaxton so hard to consent to palliative care for her mother.

Shaken but unbowed, Plaxton asked the head nurse to let her speak to the nurse who had been directly caring for her mother.

Fortunately, that second nurse was kind, and agreed that palliative care was not appropriate for Plaxton's mother. She agreed instead to allow her to not take the bowel-cleaning meds, and to coax her to eat and drink to recover her fluids and strength. She also said she'd keep an eye on the slight fever Plaxton's mother had.

Over the next few days this plan worked, and the nurse told Plaxton she needn't worry.

That's why it hit Plaxton like a gut punch when on April 10 she got a call from another nurse, who was panicking. She told Plaxton her mom was struggling to breathe and "going fast."

The nurse said the care home couldn't transfer her to the hospital. She asked Plaxton's permission for the doctor to give her mother *"a shot to ease her passing."*

(The nurse didn't tell Plaxton what 'the shot' was. But it very likely was morphine, which is routinely used to relieve severe pain. A high enough dose of morphine slows people's breathing and hastens their death.)

Plaxton was reeling. She immediately consulted with her sister; together they decided to give consent for the shot. Three hours later their mother was dead.

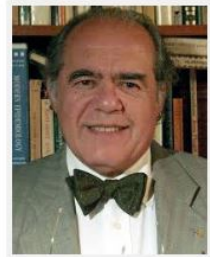
https://www.italiaisraeletoday.it/e-in-svezia-curano-il-covid-negli-anziani-con-leutanasia-attiva/

di **Giulio Meotti** –

"In Svezia 'curiamo' il Covid negli anziani con l'eutanasia". Ho raccontato sul Foglio come nel paese col più alto numero di morti pro capite al mondo agli anziani che si ammalano danno la morfina, anziché l'ossigeno. Lo denunciano anche molti medici, come Yngve Gustafson sul principale giornale svedese: "Somministrare regolarmente morfina e midazolam è eutanasia attiva, se non qualcosa di peggio. Abbiamo rinunciato agli anziani che avrebbero potuto avere una possibilità di sopravvivenza".

Marcello Ferrada de Noli

Lo raccontano anche molte infermiere, come Latifa Löfvenberg: "Ci hanno detto di non mandare nessuno in ospedale, anche se hanno 65 anni". Avevo iniziato a raccontarlo un mese fa, quando il celebre epidemiologo Marcello Ferrada de Noli che ha lavorato al Karolinska di Stoccolma disse che "la Svezia sta sacrificando gli anziani". Il paese di Greta, dell'ambientalismo, delle cause buone, in questa crisi ha mostrato tutto il suo nichilismo. E' la barbarie umanitaria.

https://www.alliancevita.org/en/2020/03/press-release-coronavirus-elderly-at-greater-risk-of-discrimination-and-euthanasia/

Alliance VITA warns that serious ethical transgressions are looming over many elderly individuals during these unforeseen circumstances of contamination, confinement, lack of medical equipment and personnel, and diminishing capacity of hospital resuscitation units.

Alliance VITA, informed by its listeners of the SOS End of Life listening service, as well as by a large number of caregivers, members of its teams and its medical experts, alerts about this serious situation. The elderly, who were already facing loneliness, are now isolated and defenseless, in danger of having their dignity trampled upon and even threatened with losing their lives.

Due to insufficient experience and training of some doctors, **multiple sedation protocols are hastily implemented, based solely on age, and neglecting any endeavors for treatment. This is equivalent to discrimination, a denial of appropriate healthcare which can end up in a form of euthanasia.**

https://www.wsj.com/articles/coronavirus-is-taking-a-high-toll-on-swedens-elderly-families-blame-the-government-11592479430

WORLD | EUROPE

Coronavirus Is Taking a High Toll on Sweden's Elderly. Families Blame the Government.

Discontent is growing over official triage guidelines critics say too often deny elderly patients vital care

By Bojan Pancevski | Photographs by Anna Tärnhuvud for The Wall Street Journal

Updated June 18, 2020 11:19 am ET

PRINT TEXT 165

When 81-year-old Jan Andersson fell ill with Covid-19 at a nursing home in the Swedish town of Märsta, a doctor consulted by phone ordered palliative care, including morphine, instead of trying to help him fend off the infection.

Mr. Andersson's son, Thomas Andersson, says he was told his father was too frail for other treatment. The younger man disagreed and, after arguing with the physician, summoned journalists and insisted his father be given lifesaving care. Mr. Andersson has since recovered.

https://milano.corriere.it/notizie/cronaca/20_aprile_14/paolo-gulisano-lecco-giusy-anziana-polmonite-79-anni-strappata-all-eutanasia-coronavirus-casa-guarita-74cb42d8-7e12-11ea-9d1e-3b71f043fc58.shtml

I fatti. Giusy, cardiopatica, con gravi problemi di salute pregressi, viene portata in ospedale a Lecco perché da giorni accusa un forte dolore al petto. La lastra non lascia spazio a interpretazioni: polmonite interstiziale. «Il dottore del pronto soccorso mi ha detto che probabilmente aveva il virus, anche se il tampone non gli è mai stato fatto, nonostante lo abbia ripetutamente chiesto — racconta Alessandra —. Mi ha spiegato che la situazione era molto compromessa, che se non volevo vederla morire soffocata nell'arco di 48 ore mi conveniva lasciarla in ospedale dove sarebbe stata accompagnata dolcemente con la morfina. Intubarla era impensabile, troppo anziana, troppo debilitata. Mi è crollato il mondo addosso. Ho chiamato il mio medico di base e poi l'amico Paolo Gulisano. Entrambi non ci hanno pensato un istante. Portala a casa, mi hanno detto. E così ho fatto». Nelle ultime righe del referto si legge: «I parenti resi edotti della situazione, prospettate le eventuali complicanze, rifiutano il ricovero assumendosi ogni responsabilità».

Il resto della storia è lo stesso Gulisano a raccontarla nel suo blog. «Ho detto ad Alessandra che mi sarei preso cura io della sua mamma anche se non potevo garantirle nulla — spiega l'epidemiologo —. Le ho prescritto una terapia che non è ancora ufficialmente adottata negli ospedali previo trials clinici e studi in doppio cieco, ma c'era da salvare una vita, e non ho avuto dubbi che occorresse tentare: azitromicina, clorochina, eparina, maltodestrina e naturalmente ossigeno. Pastiglie per bocca, 15 euro di spesa totale. Sono passate due settimane, Giusy sta bene, è in piedi, i parametri sono tutti buoni. Se fosse rimasta in ospedale dopo 48 ore di accompagnamento dolce sarebbe morta, da sola, senza più vedere nessuno dei suoi cari, come successo a tantissime altre persone. La sentenza di morte non è stata

https://www.lifenews.com/2020/06/25/sweden-may-have-euthanized-elderly-coronavirus-patients-people-suffocated-it-was-horrible-to-watch/

The health authorities have received many complaints about how elderly relatives were treated. A consistent theme is that nursing home residents with suspected Covid-19 were immediately placed on palliative care and given morphine and denied supplementary oxygen and intravenous fluids and nutrition. For many this was effectively a death sentence.

"People suffocated, it was horrible to watch. One patient asked me what I was giving him when I gave him the morphine injection, and I lied to him," said Latifa Löfvenberg, a nurse. "Many died before their time. It was very, very difficult."

The issue has even generated an internet petition, "Everyone has a right to oxygen!" which contends that "this discrimination is unacceptable and illegal as well."

The problem seems to have been the guidelines issued by the National Board of Health and Welfare. At the start of the pandemic it suggested that doctors triage patients according to their so-called biological age, weighing overall health and the prospects for recovery, before making treatment decisions.

"Doctors overseeing nursing-home care were advised to keep their distance from residents because of infection risks and told to carefully weigh the condition of patients before referring them to hospitals, said Thomas Linden, chief medical officer of Sweden's National Board of Health and Welfare."

The idea was to keep hospital ICUs from being overwhelmed by older patients with a low chance of survival. However, the surge never happened. Instead, the elderly were denied access to unused facilities. "These guidelines have too often resulted in older patients being denied treatment, even when hospitals were operating below capacity," according to

"Older people are routinely being given morphine and midazolam, which are respiratory-inhibiting," he told the Svenska Dagbladet newspaper.

And speaking in the Aftonbladet Daily, another newspaper, he was more specific:

> In elderly homes, in principle, only palliative care has been prescribed, which means that you get morphine, midazolam and haldol to prevent being nauseated and vomited by morphine. It is a treatment that almost 100 percent certainly leads to death. Giving both midazolam and morphine inhibits breathing. If you have trouble breathing, you quickly get such an oxygen deficiency that you die.

Was this euthanasia? Gustafsson was blunt. Yes, he said. "Yes, I could almost imagine using even stronger words. That it is about the same as these people being killed. It's basically a hundred percent way, much like the electric chair. It is about as effective."

Even the government has admitted that the strategy was misguided. "We have to admit that when it comes to elderly care and the spread of infection, that has not worked," Prime Minister Stefan Löfven told Swedish newspaper The Aftonbladet Daily. "Too many old people have died here."

https://www.paologulisano.com/disabili-e-anziani-leutanasia-da-covid-e-un-fatto-globale/

Lo Stato dell'Alabama ha emanato delle direttive, un documento intitolato "Scarce Resource Management" è il caso più eclatante. Il documento prevede che i "disabili psichici sono candidati improbabili per il supporto alla respirazione". Un modo elegante per dire che potrebbe esserci l'abbandono terapeutico – e quindi la morte – per disabili psichici, una classificazione in cui potrebbero rientrare moltissime persone, dai Down a persone con ritardi mentali. Un criterio eutanasico che ricorda i progetti nazisti di eliminazione degli "esseri inferiori".

Anche in Europa la cultura della morte sta cercando di cogliere le opportunità offerte dall'epidemia di Covid-19: in Olanda, al fine di evitare il sovraffollamento degli ospedali già visto in Italia e altri Paesi, le autorità sanitarie hanno dato disposizioni ai medici di base di contattare i loro assistiti anziani invitandoli ad esprimere le loro volontà anticipate di trattamento rispetto alle cure intensive. Si fa capire che devono optare se essere curati con i respiratori, oppure – nel caso prendano in considerazione il fatto che in fondo hanno vissuto abbastanza a lungo e che non ci sono risorse sufficienti per tutti – "spontaneamente" rinuncino a farsi curare e si facciano accompagnare dolcemente verso la morte.

Questa è dunque la situazione in molti Paesi. E l'Italia? Dietro la retorica che ci viene propinata dai media, che vuole presentare un quadro di un Paese che è impegnato nella lotta al virus ma che evidentemente deve fronteggiare un nemico troppo potente, si intravede un quadro diverso e sul quale occorrerebbe ragionare in modo attento e approfondito.

Il punto di partenza è quel tasso di mortalità del 10% che è un valore assolutamente anomalo, dal punto di vista epidemiologico. Di gran lunga superiore a quello di tutti i Paesi colpiti. Sulla *Nuova Bussola* se ne è già parlato, ma bisogna tornare su questo argomento.

Forse l'Italia non avrà dichiarato apertamente le proprie intenzioni eugenetiche, ma le testimonianze che vengono dagli ospedali dicono di una pratica adottata fin dai primi giorni dell'epidemia: quella di non curare tutti, ma solo le persone al di sotto dei 75 anni. Gli ospedali, specie quelli del Nord, ci è stato più volte ripetuto, sono al limite della capienza, al limite del collasso. Pertanto, è stato fatto intendere che queste morti – magari evitabili – erano necessarie per un "bene comune".

Come sottolineato dal Dott. Gulisano, alcuni di questi episodi sono talmente eclatanti e simili tra loro in tutti i paesi colpiti dalla "pandemia" da far dubitare che ciascun operatore sanitario abbia potuto adottare di sua spontanea iniziativa un approccio così estremo. Tutto lascia intendere che sia stata al contrario qualche linea guida diramata a livello internazionale ad aver incoraggiato un'applicazione indiscriminata di cure "palliative" su pazienti.

Mi è parso a questo punto doveroso fare una ricerca per verificare l'esistenza e l'eventuale natura di tali linee guida.

Qui di seguito può trovare alcuni dei risultati, a dir poco inquietanti:

English auto translation:

As Dr Gulisano pointed out, some of these episodes are so striking and similar in all the countries affected by the "pandemic" that it is doubtful that any health worker could have taken such an extreme approach on his own initiative. All the indications are that some international guidelines have encouraged the indiscriminate application of palliative care to patients.

It seemed to me at this point that research should be carried out into the existence and possible nature of such guidelines.

Some of the results are disturbing, to say the least:

Documento 1: http://globalpalliativecare.org/covid-19/uploads/briefing-notes/briefing-note-palliative-care-for-older-persons-infected-with-covid-19.pdf

Key Facts

- Palliative care is an essential clinical component of Covid-19 care[2].
- Older persons with Covid-19 symptoms, typically severe breathlessness, agitation and fever, require either hospital admission for critical care, or referral to palliative care[3].
- Older persons tend to present atypical manifestations of diseases; Covid-19 should be suspected where there is sudden change in normal behaviours.
- Men and those with underlying health conditions that affect the cardiovascular, respiratory, and immune systems are at highest risk of becoming seriously ill, with 15% mortality for those over 80 years.[1]
- Older persons affected by humanitarian emergencies and living in refugee camps or informal settlements are particularly susceptible to severe symptoms. Living conditions make protective measures like distancing, isolation and regular handwashing impossible. Lack of health services makes access to care, including palliative care, challenging.
- International law and *opinio juris* (expert legal opinion) recognise that older persons in all settings (home, nursing homes, prison, refugee camps, shelters) have a right to access palliative care services and essential palliative care medicines as a component of the right to the highest attainable standard of health. Given the heightened risk older persons face and scarce health resources, attention needs to be paid to the provision of palliative care services. Older persons have the right to die with dignity and without pain[4].
- Older persons in most countries, especially older women, are disproportionally likely to experience poverty, limiting their access to affordable healthcare, including palliative care, medicines, and essential equipment to support patients with Covid-19. Older women are often informal caregivers; older men and women caregivers may be exposed to the virus if caring

Palliative Care in the COVID-19 Pandemic

Briefing Note

Recommendations for Symptom Control of Patients with COVID-19

Issue

COVID-19 is an acute disease with a clinical presentation of pneumonia and accompanying respiratory insufficiency. Thus, typical symptoms are dyspnoea (breathlessness), cough, weakness and fever. Other symptoms such as anxiety, panic, restlessness and delirium have been reported. Patients with rapidly deteriorating respiratory failure and who do not receive intensive care, develop acute respiratory distress syndrome (ARDS) with severe breathlessness, anxiety and panic, requiring rapid intervention for symptom control.

This briefing note covers the symptomatic treatment of these burdening symptoms. Other clinical problems such as fever, ventilatory failure, thrombosis or coagulopathies are not covered in this brief.

Si noti la genericità dei sintomi descritti (il virus provoca ansia?) con particolare riferimento alla triste storia della signora Wanda, già affetta da sporadici attacchi di panico e imbottita di antipsicotici (oltre che di morfina) perché giudicata come "in preda al delirio" per aver rifiutato il casco CPAP.

English auto translation:

Note the generic nature of the symptoms described (does the virus cause anxiety?) with particular reference to the sad story of Mrs. Wanda, already suffering from sporadic panic attacks and stuffed with antipsychotics (as well as morphine) because she was judged to be "delirious" for refusing the CPAP helmet.

Recommended treatment:

i. Opioid-naive patients able to take oral medications:

*Morphine oral 2.5–5 mg 4-hourly		
*Morphine slow release	10–0–10 mg**	(8.00 – 0 – 20.00)
***Lactulose	10–0–0 ml	
Supplement antiemetic if required: Haloperidol 0,5–1 mg at night and up to 2-hourly prn		
+ rescue medication as required, up to once per hour (immediate release opioids; 1/6 of the daily dosage)		
Morphine solution	2.5–5 mg**	(= 2-4 drops Morphine solution 2%)
alternatively, Morphine i.v. short infusion/ s.c.	1–3 mg**	
* or alternative opioids /****rapid titration according to symptom intensity** /***or alternative laxatives (docusate, macrogol, etc)		

ii. Patients already on opioids and able to take oral medications

- Increase dosage of opioids by 20%
- adapt rescue medication (immediate release opioids, 1/6 of daily dosage)
- rescue medication as required, up to once per hour
- continue constipation prophylaxis (f.e. Macrogol)

	Example:	**Increase by 20%**
*Morphine immediate release	30 mg prn	**40 mg prn up to once per hour.

Morphine dosages >240mg/d: change application route to parenteral (1/3 dosage - 10%)

* or alternative opioids /****rapid titration according to symptom intensity**

4. Restlessness and Anxiety: Breathlessness frequently generates restlessness and anxiety. Patients with acute COVID-19 infection, respiratory insufficiency and the decision to limit invasive ventilation therapy require frequent assessment and rapid treatment of acute and exacerbating breathlessness and anxiety.

a. Pharmacological treatment of anxiety and restlessness in patients with breathlessness, supplementing the opioid medication (example)

Lorazepam 1 mg p.o./s.l. (solution with 2 ml water if necessary) prn, up to once per 30 min
or
Midazolam 2.5-5 mg i.v. short infusion/s.c. prn, up to once per 30 min

b. Pharmacological treatment of refractory anxiety and restlessness in patients with breathlessness

- early change to parenteral application route i.v. (or s.c.) continuously or 4-hourly
- Midazolam-infusion pump (in combination with morphine)
- starting dose: Midazolam 10 mg/24 h, titrate to effect

Example → 10 mg Midazolam ad 50 ml NaCl 0.9%, rate 2 ml/h
or → Midazolam 2.5-5 mg short infusion/s.c. 4-hourly

5. Acute Agitation and Delirium: Patients with COVID-19 infections frequently suffer from agitation or delirium caused by infection, hypoxemia or isolation. Agitation and delirium require timely interventions. Potential causal factors have to be assessed and treated, including pain, constipation or full bladder.

a. Non-pharmacological interventions include assessment and treatment of potential causal factors, communication, provision of a quiet environment (well-lit and quiet room) and orientation for the patient (information on where and who the patient is, as well as on the actual situation they are in).

b. Pharmacological treatment of agitation and delirium

Predominantly motor **restlessness** (example)
Midazolam 2.5–5 mg i.v. short infusion/s.c. prn, up to once per 30 min
or
Lorazepam 0.5–1 mg s.l./p.o. prn, up to once per 30 min
or
Midazolam continuously i.v. or s.c. 10 mg/24 h
Example 10 mg Midazolam ad 50 ml NaCl 0.9%, rate 2 ml/h

Hallucinations and confusion
Haloperidol 1-2 mg s.c. prn, up to once per 30 min
or
Haloperidol s.c. continuously 2–5 mg/24 h
Example 5 mg Haloperidol ad 50 ml NaCl 0.9%, rate 2 ml/h

Qui un altro documento, questa volta dedicato ai pazienti “triaged to supportive end of life care at home”:

Auto English translation:

Here another document, this time dedicated to patients "triaged to supportive end of life care at home":

Fonte: https://www.sicp.it/wp-content/uploads/2020/06/ESMOemergency-palliation-protocol-for-non-ventilated-home-care-patient-20.pdf

Palliation of breathlessness/dyspnoea

If breathless despite oxygen supplementation

- Start regular opioid: morphine CR 10-30 mg 12 hrly, or transdermal fentanyl 12 mcg/hr, or oxycodone CR 10-20 mg 12 hrly
- SC Morphine 2.5-5 mg as needed, up to every 20 minutes
- Provide IV/SC antiemetic if necessary

If this is inadequate

- Increase dose of long acting opioid
- Rescue dose of transmucosal or intranasal fentanyl or SC morphine 5 mg as needed, up to every 20 minutes
- Titrate to effect, dose can be increased every 24 hours

OR

- Start morphine infusion 15-30 mg in 100 cc SC over 24 hr
- Rescue dose 5 mg SC push
- Monitor for adequacy of relief, excessive drowsiness
- Titrate to effect, dose can be increased every 12 hours

BE PREPARED TO INCREASE DOSING RAPIDLY IF NEEDED

If agitated

- Use midazolam 2.5 mg SC push, or rectal diazep[illegible]0 mg as needed
- If repeated doses are necessary, start midazolam infusion 1 mg/hr
- Titrate midazolam to effect

Alternative

- olanzapine 5-10 mg SL/SC (8-12 hrly)
- chlorpormazine 25-50mg IM/IV (8 hrly)

BE PREPARED TO INCREASE DOSING RAPIDLY IF NEEDED

If still distressed, consider palliative sedation (see below)

- Call palliative care consultation 24/7

Monitoring

- ✓ Adequacy of relief
- ✓ Excessive sedation
- ✓ Side effects
- ✓ Frequent use of rescue doses

CR=controlled release; hr=hour; hrly=hourly; IV=intravenous; IM=intramuscular; mg=milligram; mcg=microgram; PO=orally; SC=subcutaneous; SL=sublingual

Oltre alla scritta in stampatello rosso: “SIATE PRONTI AD AUMENTARE RAPIDAMENTE IL DOSAGGIO SE NECESSARIO”, Il documento contiene un interessante disclaimer, scritto invece in caratteri minuscoli:

Auto translation in English:

In addition to the red print: "BE READY TO RAPIDLY INCREASE THE DOSAGE IF YOU NEED it", the document contains an interesting disclaimer, written in lower case:

Disclaimer: The *ESMO COVID-19 palliative care pathways* do not constitute an order. Any clinician seeking to treat a patient using these templates is expected to use independent medical judgment in the context of individual clinical circumstances of a specific patient's care or treatment. ESMO does not warrant the accuracy, currency, or completeness of the *ESMO COVID-19 palliative care pathways* regarding the use or the results of the use of the ESMO templates in treatment. In no event shall ESMO or its experts be liable for any damages or consequential damages arising out of or in connection with the use of the ESMO templates.

In Francia, la prescrizione off-label del Rivotril, giustificata sulla base della mancanza di scorte di midazolam e destinata esclusivamente ai pazienti covid (in combinazione con la morfina) ha suscitato tale scalpore da richiedere l’intervento di una campagna a mezzo stampa per spiegare al pubblico che la sedazione profonda non può essere in nessun caso considerata eutanasia:

Auto English translation

In France, the off-label prescription of Rivotril, justified on the basis of the lack of stocks of midazolam and intended exclusively for covid patients (in combination with morphine), caused such a stir that it required a press campaign to explain to the public that deep sedation can under no circumstances be considered euthanasia:

https://www.lavoixdunord.fr/736161/article/2020-04-04/coronavirus-le-rivotril-et-l-amalgame-entre-soins-palliatifs-et-euthanasie

Ce qui est vrai

Oui, le Rivotril, habituellement prescrit pour l'épilepsie et certaines douleurs neuropathiques, « *permet aussi la sédation continue et profonde* », c'est-à-dire « *de soulager les patients en fin de vie* », explique Franck Roussel, secrétaire général du conseil départemental de l'ordre national des médecins. Il pourra être délivré « *comme traitement de confort, pour apaiser* », par les pharmacies d'officine sur ordonnance d'un médecin de ville pour la prise en charge palliative des malades du Covid-19 restés ou revenus à domicile.

Ce qui est faux

Autoriser l'usage du Rivotril injectable pour prendre en charge les patients atteints du SARS-CoV-2 ne revient pas à autoriser l'euthanasie. Son usage reste « *très encadré, réservé à un infirmier avec un protocole très strict, une traçabilité* », précise le docteur Roussel. « *On reste dans le cadre de la loi du 2 février 2016 sur la fin de vie* », explique Jérôme Robillard, de Hospimedia. Loi qui instaure notamment un droit à la sédation profonde et continue jusqu'au décès pour les personnes dont le pronostic vital est engagé à court terme.

> ***« Il va y avoir une surmortalité chez les personnes âgées due au Covid-19 et non à une vague d'euthanasie »***

Purtroppo, documenti pubblicati in paesi dove l'eutanasia è legale evidenziano come la combinazione di morfina e benzodiazepine sia l'approccio farmacologico alla base sia della sedazione profonda (e quindi delle cosiddette cure palliative) sia dell'eutanasia tout-court. Il dosaggio dei farmaci e le condizioni di base del paziente sono le uniche discriminanti tra un esito e l'altro.

Qui un documento di un'università belga:

Auto translation in English:

Unfortunately, documents published in countries where euthanasia is legal show that the combination of morphine and benzodiazepines is the pharmacological approach behind both deep sedation (and therefore so-called palliative care) and euthanasia tout-court. The dosage of the drugs and the basic conditions of the patient are the only discriminating factors between one outcome and the other.

Here a document from a Belgian university:

https://orbi.uliege.be/bitstream/2268/225060/1/Relieving%20suffering%20or%20intentionally%20hastening%20death-%20where%20do%20you%20draw%20the%20line%3F.pdf

Relieving suffering or intentionally hastening death: Where do you draw the line?*

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Objective: End-of-life practices vary worldwide. The objective was to demonstrate that there is no clear-cut distinction between treatments administered to relieve pain and suffering and those intended to shorten the dying process.

Design: Secondary analysis of a prospective, observational study.

Setting: Thirty-seven intensive care units in 17 European countries.

Patients: Consecutive patients dying or with any limitation of therapy.

Interventions: Evaluation of the type of end-of-life category; dates and times of intensive care unit admission, death, or discharge; and decisions to limit therapy, medication, and doses used for active shortening of the dying process and the intent of the doctors prescribing the medication.

Measurements and Main Results: Limitation of life-sustaining therapy occurred in 3,086 (72.6%) of 4,248 patients, and 94 (2.2%) underwent active shortening of the dying process. Medication for active shortening of the dying process included administration of opiates (morphine to 71 patients) or benzodiazepines (diazepam to 54 patients) alone or in combination. The median dosage for morphine was 25.0 mg/hr and for diazepam 20.8 mg/hr. Doses of opiates and benzodiazepines were no higher than mean doses used with withdrawal in previous studies in 20 of 66 patients and were within the ranges of doses used in all but one patient. Doctors considered that medications for active shortening of the dying process definitely led to the patient's death in 72 patients (77%), probably led to the patient's death in 11 (12%), and were unlikely to have led to death in 11 (12%) patients.

Conclusions: There is a gray area in end-of-life care between treatments administered to relieve pain and suffering and those intended to shorten the dying process. (Crit Care Med 2008; 36:8–13)

Key Words: end-of-life decisions; euthanasia; shortening the dying process; withdrawing treatment; intensive care units; double effect
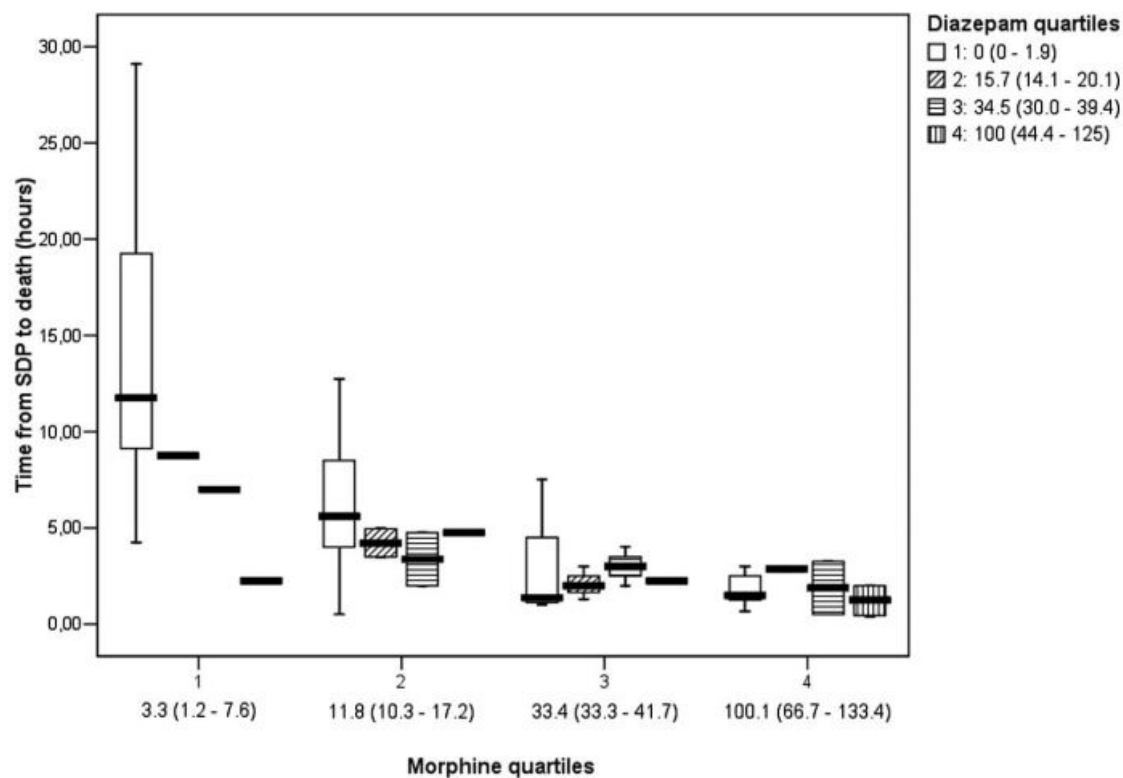
Figure 1. Time from shortening of dying process (*SDP*) to death according to the doses of the medication (morphine and diazepam equivalents, mg/hr) administered (quartiles). This analysis includes only observations where no drugs other than morphine or diazepam were used.
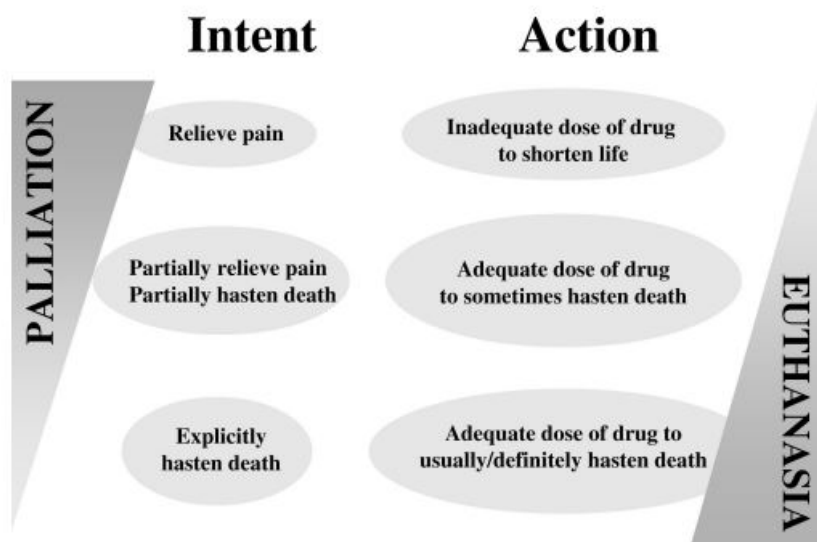
Figure 2. The spectrum of actions between palliative care and euthanasia.

Ancora più inquietante questo passaggio di questo libro, contenente istruzioni su come ottenere l’eutanasia nei paesi dove non è legale:

Auto translation in English:

Even more disturbing is this passage in this book, which contains instructions on how to obtain euthanasia in countries where it is not legal:

https://books.google.it/books?id=6icpxFlM_UQC&pg=PA113&lpg=PA113&dq=morphine+mydazolam+euthanasia&source=bl&ots=wei6FI6UKy&sig=ACfU3U1DWA1bVSxCUjcNPGy3K8o-IOElkw&hl=it&sa=X&ved=2ahUKEwivrtjnkqrqAhXOCuwKHWWCD4MQ6AEwA3oECAoQAQ#v=onepage&q=morphine%20mydazolam%20euthanasia&f=false

When doctor and patient begin speaking in this tangential way, there is a very real chance that significant misunderstandings can occur. It is not uncommon for a doctor to promise 'every assistance when the time comes' and for the patient to draw immense comfort from this. A patient might even imagine that the doctor is saying that 'when things deteriorate I will give you access to lethal drugs.' In reality, this is highly unlikely. Few medical doctors would risk de-registration and a significant jail term. The only assistance likely from the doctor, is for them to initiate slow euthanasia, with the patient being admitted to an institution, a hospital or hospice. And there may well be argument about when the process should commence.

Exit suggests that in situations where slow euthanasia has appeal, that early discussions between patient and doctor take place. Be blunt. If the doctor promises help 'when the time comes', insist on knowing who will decide when that time is, and exactly what sort of help is being promised? If there is any attempt to skirt or dismiss your questions, be very wary. Try discussing the issue with another doctor, or look into an alternative end of life strategy.

This use of morphine by doctors to end life has led to the common community misconception that the best drug to use to end one's life is morphine - it must be, because that's the drug doctors use! This unfortunate misunderstanding leads to many failed suicide attempts.

And the process must be slow. Indeed, slow euthanasia can often take days or even weeks. Often the patient is given a sedative that keeps them asleep through the whole process; midazolam is the drug of choice. Coupled with morphine, this morphine - midazolam mix (known as 'Double M Therapy') places the patient in an induced coma for the time needed to raise the morphine level sufficiently. Double M therapy allows the patient to sleep through their own death and gives rise to another name for the process - 'pharmacological oblivion.'

The doctor still makes the assessment about the need for larger and larger morphine doses. Here the decision is based not on the patient's complaints, but upon a clinical assessment of the unconscious person.

La combinazione di midazolam e morfina ("Double M Therapy") pare essere la scelta privilegiata per indurre una "lenta eutanasia", per la quale difficilmente un medico potrebbe essere perseguito.

English auto translation:

The combination of midazolam and morphine ("Double M Therapy") seems to be the preferred choice to induce a "slow euthanasia", for which a doctor could hardly be prosecuted.

Documenti ufficiali riportano inoltre che negli ultimi anni il midazolam ha progressivamente sostituito i barbiturici nelle pratiche di suicidio assistito e persino nelle esecuzioni di condanne a morte:

Auto translation into English:

Official documents also report that in recent years midazolam has gradually replaced barbiturates in assisted suicide practices and even in executions of death sentences:

https://academic.oup.com/jlb/article/4/2/424/4265564

Table 1.
Lethal medications used in PAS and executions.

Drug name (trade name)	Therapeutic class	Medical uses	Lethal protocols	Unique pharmacological characteristics
Sodium thiopental (Pentothal)[6]	Barbiturate	Anesthetic; used in surgery in poorer countries; primary execution drug till 2010	PAS drug in Europe; used in three-drug and one-drug executions (first drug)	Ultra-rapid onset; short lasting
Pentobarbital (Nembutal)[7]	Barbiturate	Sedative; pre-anesthetic; treats insomnia	PAS drug; used in one-drug, two-drug, and three-drug executions (first drug)	Slow onset; long lasting
Secobarbital (Seconal)[8]	Barbiturate	Sedative; treats insomnia	PAS drug; proposed for executions, but never used	Rapid onset; short lasting
Phenobarbital (Luminal)	Barbiturate	Sedative; treats seizures	PAS drug; proposed for executions, but never used	Ultra-slow onset; long lasting
Midazolam (Versed)[9]	Benzodiazepine	Sedative; treats anxiety and amnesia	Used in one-drug, two-drug, and three-drug protocols (first drug)	Rapid onset; intermediate-lasting; effects capped at 'lower level of sedation'

Alla luce di queste considerazioni e delle combinazioni di farmaci consigliati nelle direttive per i pazienti covid, i seguenti appelli all'estensione delle cure palliative sull'onda dell'emergenza pandemica (diffusi dagli stessi autori delle linee guida farmacologiche, si veda il caso del consulente dell'OMS Lukas Radbruch, co-autore del documento 1) risultano a dir poco sconcertanti:

Auto translation into English:

In the light of these considerations and the drug combinations recommended in the covid patient guidelines, the following calls for the extension of palliative care in the wake of the pandemic emergency (disseminated by the authors of the drug guidelines themselves, see the case of WHO consultant Lukas Radbruch, co-author of document 1) are disconcerting to say the least:

https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30964-8.pdf

Panel: **Strategies to extend palliative care during and after the COVID-19 pandemic**

Immediate responsiveness to adapt to pandemic parameters

Optimise cooperation and coordination

- Initiate formal and informal pathways for collective action and exchange by governments, bilateral and multilateral organisations, civil society, and the private sector based on the principle of solidarity.

Preserve continuity of care

- Ensure the availability and rational use of personal protective equipment and encourage self-care among palliative care health-care professionals and all caregivers.
- Ensure an adequate and balanced supply of opioid medication to all patients for relief of breathlessness and pain by instituting the simplified procedures of the International Narcotics Control Board.
- Conduct rapid training for all medical personnel to address additional palliative care needs of COVID-19 patients.
- Engage technology partners to equip community health workers with telehealth capabilities to virtually conduct home-based palliative care activities.
- Enable families to virtually visit and partake in health decisions with loved ones, especially at the end of life to address the almost universal fear of dying alone.

Enhance social support

- Enlist informal networks of community-based and faith-based organisations to mobilise and train a citizen volunteer workforce that is ready and able to teleconnect with patients in need of basic social support, delivering on palliative care's cornerstone feature—compassionate care.

Assess emerging needs

- Link with contact tracing activities and testing sites to collect data from the general public to better understand the social dimension of pandemic suffering.

Long-term preparedness strategies that embed palliative care into the core of medicine

- Expand all medical, nursing, social work, and community health worker curricula, as well as training of clergy, to include core palliative care competencies.
- Establish standard and resource-stratified palliative care guidelines and protocols for different stages of a pandemic and based on rapidly evolving situations and scenarios.

https://www.sanita24.ilsole24ore.com/art/lavoro-e-professione/2020-04-03/coronavirusanestesisti-e-animatori-protocollo-le-cure-palliative-091808.php?uuid=AD1KKuH

Alla luce di queste considerazioni la Società italiana di
cure pallative-Sicp, la Società italiana di anestesia, analgesia, rianimazione e terapia intensiva-Siaarti e la Federazione cure palliative-Fcp hanno pubblicato oggi il Position Paper congiunto "Le Cure Palliative nel trattamento dei malati COVID-19/SARS- CoV-2" nel quale si sottolinea l'importanza del trattamento dei sintomi sopra indicati e la grave sofferenza correlata "soprattutto in quei malati che, non essendo candidati alle cure intensive perché non appropriate clinicamente e/o sproporzionate o perché il livello di gravità non è tale da renderle comunque necessarie, rischiano concretamente di sperimentare una intollerabile intensificazione dei predetti sintomi".
"Ci è sembrato opportuno lanciare questo Position Paper", sottolinea Italo Penco, presidente SICP, "alla luce di quanto sta accadendo negli ospedali e nelle RSA dove l'emergenza ha sconvolto la normale modalità di operare ed è necessario organizzare l'assistenza per garantire ai malati affetti da CoViD-19/SARS-CoV-2 la possibilità di non soffrire ricevendo cure adeguate con il supporto di chi ha competenze in medicina palliativa".
"Si tratta di un documento puntuale, sintetico e tempestivo", commenta Flavia Petrini, presidente Siaarti, "che abbiamo desiderato proporre raccogliendo anche le tante istanze che ci arrivano dai colleghi delle varie specialità coinvolti nella gestione di questa grande emergenza nazionale. Per noi è fondamentale ricordare alle istituzioni sanitarie che la Legge sulla terapia del dolore - la legge che si prefiggeva di assicurare migliore risposta delle reti di terapia del dolore e di cure palliative - non può oggi rischiare di rimanere una grande incompiuta proprio nel momento in cui c'è immenso bisogno della sua totale e concreta attuazione".

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7176394/

In this most challenging time, health responders can take advantage of palliative care know-how to focus on compassionate care and dignity, provide rational access to essential opioid medicines, and mitigate social isolation at the end of life and caregiver distress. The call to fully incorporate palliative care into global health[1,22] could finally be realised in the urgency of the pandemic. If so, the COVID-19 pandemic will have catalysed medicine to better alleviate suffering in life and death.[23]

LR is chair of the board of directors of the International Association for Hospice and Palliative Care. FMK reports grants from the American Cancer Society, Asociacion Mexicana de Industrias de Investigacion Farmaceutica, Chinoin, GDS, JM Foundation, Mayday Fund, NADRO, Novartis, Open Society Foundation, Pfizer, US Cancer Pain Relief Committee, VITAS Healthcare, Wellcome Trust, and Grunenthal; grants and personal fees for a lecture and non-financial support from Roche; and grants, consulting fees, and non-financial support from Merck/EMD Serono. CdJ is President of the International Narcotics Control Board. AB reports consulting fees from GDS, US Cancer Pain Relief Committee, Mayday Fund, JM Foundation, Pfizer, Lien Foundation, and Roche. LdL declares no competing interests.

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1 Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: the *Lancet* Commission report. *Lancet* 2018; **391:** 1391–454.

2 Arya A, Buchman S, Gagnon B, Downar J. Pandemic palliative care: beyond ventilators and saving lives. *CMAJ* 2020; published online March 31. DOI:10.1503/cmaj.200465.

La domanda che sorge spontanea è la seguente: è stata davvero la decisione di trasferire malati di covid nelle case di riposo (una decisione evidentemente scellerata presa inspiegabilmente in quasi tutti i paesi che hanno registrato un così alto tasso di mortalità all'interno di tali strutture) a determinare una così alta mortalità tra gli ospiti? Quante di queste persone sarebbero comunque guarite con un approccio terapeutico adeguato?

E ancora: è possibile che queste direttive, così come quella che prevedeva un limite di età per l'accesso ai reparti di terapia intensiva (peraltro in molti casi in assenza di una reale congestione del sistema sanitario) siano in fondo specchietti per le allodole da dare in pasto all'indignazione dell'opinione pubblica per nascondere fatti ben più gravi, ovvero l'abbandono terapeutico tout court e l'adozione indiscriminata negli anziani di "cure palliative" che hanno determinato nella stragrande maggioranza dei casi una morte prematura del paziente? In quanti casi la positività a un test PCR si è trasformata in una vera e propria condanna a morte? E' possibile infine che questa stategia sia stata adottata scientemente con l'intento di aumentare nella cittadinanza la percezione della gravità della "pandemia" al fine di giustificare misure di limitazioni alla libertà senza precedenti nella storia del nostro paese?

English auto translation:

The question that arises is this: was it really the decision to transfer covid patients to care homes (an obviously wicked decision taken inexplicably in almost all countries with such a high mortality rate in such facilities) that led to such a high mortality among the guests? How many of these people would have been cured with an appropriate therapeutic approach anyway?

And again: is it possible that these directives, as well as the one providing for an age limit for access to intensive care wards (in many cases, however, in the absence of real congestion in the health care system), are basically mirrors for the larks to be fed to the indignation of public opinion in order to hide much more serious facts, namely the outright therapeutic abandonment and the indiscriminate adoption of "palliative care" in the elderly, which in the vast majority of cases resulted in the premature death of the patient? In how many cases has a positive PCR test turned into a death sentence? Finally, is it possible that this strategy was deliberately adopted with the intention of increasing the public's perception of the seriousness of the 'pandemic' in order to justify measures restricting freedom unprecedented in the history of our country?